

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-024294
3514 STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3514

FILED JUL 5 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 56 Yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bra-ton Nursing Home		d. STREET ADDRESS (If outside, give location) 1602 W. 37th Street	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Isaac Middle John Last Everett			4. DATE OF DEATH Month June Day 22 Year 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-25-1871	9. AGE (last birthday) 92 Yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Ford Motor Co.		11. BIRTHPLACE (City and state or country) London England
12. CITIZEN OF WHAT COUNTRY USA			13a. FATHER'S NAME Joseph Everett		
13b. MOTHER'S MAIDEN NAME Caroline Prindall			14. NAME OF HUSBAND OR WIFE Isabella Dixon Everett		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. No		
17. INFORMANT Jennett Everett 1602 W. 37th St. K.C. Mo.			Address		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Tremor Bunch</i> DUE TO (b) <i>Cerebral degenerative disease</i> DUE TO (c) <i>Cerebral sclerosis generalized</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Same</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Schistocytosis</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <i>2 30 PM</i> to <i>6-22-63</i> and last saw him alive on <i>6-22-63</i> . Death occurred at <i>2 30 PM</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J. H. Haight</i> (Degree or title)		22b. ADDRESS <i>3401 E 15th Rd</i>	22c. DATE SIGNED <i>6-24-63</i>
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-24-63	23c. NAME OF CEMETERY OR CREMATORY Mount Moriah	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Stine & McClure Kansas City, Missouri		25. DATE RECD. BY LOCAL REG. 6-24-63	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION
J. H. Haight

BY AFFIDAVIT OF

VS 300 Rev. 4/59	1	23468	3	4	0	5	2	6	7	2	8	2	94344	10	11	12	86-0	13
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Dr. Wright
3401 E 1st St
Be 1-4822
St Joseph Shop

0-38

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *William M. Turner*

Licensed Embalmer No. *4648*

P. O. Address *Kansas City, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.